MDR Tracking Number: M5-04-3081-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 05-17-04.

The IRO reviewed durable medical equipment, joint mobilization, electrical stimulation, ultrasound therapy, nerve stimulator, data analysis, therapeutic exercises, therapeutic activities, aquatic therapy, myofascial release, hand muscle testing, conference and nerve stimulator rendered from 04-03-03 through 07-01-03 that were denied based upon "U".

The IRO determined that services after 05-06-03, the neuromuscular stimulator and data analysis, sensory nerve testing and muscle testing **were not** medically necessary. The IRO determined that the office visits and treatment through 05-06-03 **were** medically necessary.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor did not prevail** on the **majority** of issues of medical necessity. Consequently, the requestor is not owed a refund of the paid IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 08-26-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

CPT code 99205 date of service 04-03-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $137.00.

CPT code 97032 date of service 04-03-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $22.00.

CPT code 72040-WP date of service 04-03-03 denied with denial code "R" (extent of injury). The carrier accepted the right shoulder injury of 04-02-03 and was disputing entitlement to medical and

indemnity benefits. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $51.00.

CPT code 72074-WP date of service 04-03-03 denied with denial code "R" (extent of injury). The carrier accepted the right shoulder injury of 04-02-03 and was disputing entitlement to medical and indemnity benefits. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $70.00.

CPT code 73030-WP date of service 04-03-03 denied with denial code "R" (extent of injury). The carrier accepted the right shoulder injury of 04-02-03 and was disputing entitlement to medical and indemnity benefits. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $60.00.

HCPCS code E1399 date of service 04-03-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) and Rule 134.202(a)(4) the carrier did not specify which service E1399 was global to, therefore the service is reviewed according to the 96 Medical Fee Guideline. Reimbursement is recommended in the amount of $45.00.

CPT code 97035 date of service 04-04-03 denied with denial code "F" fee guideline MAR reduction). The carrier has made no payment. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $22.00.

CPT code 99080-73 dates of service 04-04-03, 04-10-03 and 05-02-03 denied with denial code "F" fee guideline MAR reduction). The carrier has made no payment. Reimbursement per Rule 133.106(f)(1) is recommended in the amount of $45.00 ($15.00 X 3 DOS).

CPT code 95851 date of service 04-10-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $36.00.

CPT code 95831 date of service 04-10-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) and Rule 134.202(a)(4) the carrier did not specify which service E1399 was global to, therefore the service is reviewed according to the 96 Medical Fee Guideline. Reimbursement is recommended in the amount of $29.00.

CPT code 97750-MT date of service 04-10-03 denied with denial code "JM" (the code or modifier billed is invalid). The carrier has denied with an invalid denial code per the 96 Medical Fee Guideline MEDICINE GR I(11)(C)1)(b). Reimbursement is recommended in the amount of $43.00.

Review of CPT code 95935 (1 unit) date of service 04-24-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $53.00.

Review of CPT code 95935 (1 unit) date of service 04-24-03 denied with denial code "N" (not appropriately documented). The requestor submitted documentation to meet criteria. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $53.00

CPT code 97110 date of service 04-29-03 denied with denial code "F" (fee guideline MAR reduction). Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. Reimbursement not recommended.

CPT code 95832-59 date of service 04-29-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $45.00.

CPT code 95851-59 date of service 04-29-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) the carrier did not specify which service 95851-59 was global to, therefore the service is reviewed according to the 96 Medical Fee Guideline. Reimbursement is recommended in the amount of $36.00.

CPT code 95831-59 date of service 04-29-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) and Rule 134.202(a)(4) the carrier did not specify which service 95831-59 was global to, therefore the service is reviewed according to the 96 Medical Fee Guideline. Reimbursement is recommended in the amount of $29.00.

CPT code 97750-MT date of service 04-29-03 denied with denial code "G" (unbundling). Per Rule 133.304(c) and Rule 134.202(a)(4) the carrier did not specify which service 97750-MT was global to, therefore the service is reviewed according to the 96 Medical Fee Guideline. Reimbursement is recommended in the amount of $42.00 (MAR is $43.00, however the requestor only disputed $42.00).

CPT code 95851-59 date of service 05-13-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Reimbursement per the 96 Medical Fee Guideline is $36.00, however the requestor only disputed $29.00. Reimbursement in the amount of $29.00 is recommended.

CPT code 95831-59 date of service 05-13-03 denied with denial code "F" (fee guideline MAR reduction). The carrier has made no payment. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $29.00.

CPT code 97750-MT date of service 05-13-03 denied with code "F" (fee guideline MAR reduction).

The carrier has made no payment. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $43.00.

Review of CPT code 99455-L5 date of service 07-20-03 revealed that neither the requestor nor the respondent submitted an EOB. Per Rule 133.307(e)(2)(B) the requestor provided convincing evidence of carrier receipt of the providers request for an EOB. Per Rule 133.307(e)(3)(B) the respondent did not provide an EOB as required. Reimbursement per the 96 Medical Fee Guideline is recommended in the amount of $403.00 (requestor billed $500.00 but is only disputing $403.00).

This Findings and Decision is hereby issued this 17th day of February 2005.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division

ORDER

Pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay for the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this order. This Decision is applicable for dates of service 04-03-03 through 07-20-03 in this dispute.

This Order is hereby issued this 17th day of February 2005.

Margaret Ojeda, Manager
Medical Dispute Resolution
Medical Review Division

MQO/dlh

Enclosure: IRO Decision

1726 Cricket Hollow
Austin, Texas 78758

Ph. 512/248-9020 **Fax 512/491-5145**
IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

August 23, 2004

Re: IRO Case # M5-04-3081, amended 8/27/04, 8/31/04, 1/18/05, 2/1/05

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

Medical Information Reviewed

1. Table of disputed service
2. Explanation of benefits
3. Chart notes
4. Electrodiagnostic report 4/24/03

5. Computer analysis report 5/14/03, 4/29/03
6. Prescriptions for DME and supplement
7. FCE report 4/15/03

8. Body composition report 4/10/03
9. D.C. treatment notes
10. Carrier case summary
11. Occupational therapy evaluation 4/17/03
12. TWCC 69 reports
13. D.C. initial report 4/3/03
14. Letter of necessity 4/10/03

History

The patient injured his right shoulder in ___ when he lifted a piece of sheetrock. He saw the treating D.C. the next day. He has been treated with medication, therapeutic exercises and chiropractic manipulation .

Requested Service(s)

Durable medical equipment, joint mobilization, electrical stimulation, ultrasound therapy, nerve stimulator, data analysis, therapeutic exercises, therapeutic activities, aquatic therapy, myofascial release, hand muscle testing, conference, sensory nerve testing 4/3/03 – 7/1/03

Decision

I agree with the carrier's decision to deny all of the requested services after 5/6/03.
I agree with the decision to deny the requested neuromuscular stimulator.
I agree with the decision to deny data analysis,muscle testing and sensory nerve testing.
I disagree with the decision to deny the requested visits and office treatments (including ultrasound, joint mobilization,, myofascial release, therapeutic exercises, stimulation, therapeutic activities, aquatic therapy,) through 5/6/03.

Rationale

The patient had an adequate trial of chiropractic treatment with good results and return to work on 5/14/03. The patient had an initial VAS of 7/10, and on 5/6/03, his VAS had been reduced to 2/10, and was described by the treating D.C. as a mild, achy pain made better by exercise.
Based on the records provided for this review, it appears that the patient's condition had stabilized as of 5/6/03, and the documentation fails to show any further progress in objective findings or subjective complaints. Treatment appears to have been beneficial, reasonable and necessary through 5/6/03.
Some of the durable medical equipment prescribed is not justified by the medical records provided for review. The neuromuscular stimulator was not medically necessary as there was no documented nerve damage of the right shoulder and the patient was receiving stimulation at the D.C.'s office.
Data analysis, performance tests, range of motion testing muscle, sensory nerve testing testing and x-rays of the cervical and thoracic spine were not reasonable and necessary. The documentation provided for review fails to show objective findings and subjective complaints supporting these services.

After 5/6/03 the records indicate that the disputed services failed to be beneficial to the patient and were inappropriate and over utilized.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

_____
Daniel Y. Chin, for GP